

An Interdisciplinary Model for Meeting the Mental Health Needs of Transgender Adolescents and Young Adults: The Mount Sinai Adolescent Health Center Approach

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Transgender and gender nonconforming (TGNC) adolescents and young adults face significant mental health disparities, including increased rates of suicidality, depression, and self-harm. These disparities are multidetermined and stem, in part, from the emotional consequences of family rejection, peer and community victimization, social isolation, and discrimination and transphobia in both daily settings (e.g., school) and society as a whole. In order to meet the mental health needs of TGNC youth, we must intervene in multiple levels of youths' lives and provide gender-affirming evidence-based therapies. In this paper, we describe an integrated model of meeting the mental health needs of TGNC youth, with the ultimate goal of reducing mental health disparities. We provide guidance for macro-level interventions, including efforts to implement social change; mezzo-level interventions, including structuring a health care setting to be gender-affirming; and micro-level interventions, including gender-affirming dialectical behavior therapy, cognitive behavioral therapy, family therapy and support group interventions. Throughout, we highlight our descriptions of interventions with case examples in order to provide additional practical guidance.

In recent years, the number of transgender and gender nonconforming (TGNC) youth seeking services has increased dramatically and mental health and medical professionals have been faced with the challenge of identifying best practices in providing accessible, affirming and effective care (Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016). Moreover, due to experiences of discrimination and rejection, TGNC youth often present with disproportionate rates of mental health difficulties, further complicating their needs. In response, the nation has experienced an increase in interdisciplinary gender centers or treatment programs seeking to engage and provide care for these youth (Edwards-Leeper et al., 2016; Hsieh & Leininger, 2014; Sherer, Rosenthal, Ehrensaft, & Baum, 2012). At the Mount Sinai Adolescent Health Center, a comprehensive care clinic for youth in New York City, we have experienced a similar increase in request for services from TGNC youth. In response, we have spent the past 5 years building a comprehensive, integrated, and gender-affirming health care service for TGNC youth, with a particular focus on addressing mental

health disparities. In so doing, we aim to intervene in multiple levels of youths' social ecology and, whenever possible, provide gender-affirming, evidence-based, cognitive behavioral and dialectical behavioral therapeutic interventions. Following a review of the literature on mental health disparities among TGNC youth, we provide a detailed description of our model.

Throughout this article, we use the term transgender and gender nonconforming (TGNC) youth to describe youth who have a gender identity that is not fully aligned with their sex assigned at birth. We define gender-affirming care as care that is knowledgeable about, respectful of, and supportive of the gender identities and life experiences of TGNC people (Korell & Lorah, 2007). Furthermore, gender-affirming care explicitly recognizes that gender can be fluid and nonbinary and that gender variance is a normal part of the human experience, rather than a disorder (Edwards-Leeper et al., 2016; Hidalgo et al., 2013).

Mental Health Disparities and Contributing Factors

Research has found significant disparities in rates of mental health problems among TGNC adolescents and young adults. The 2015 U.S. Transgender Survey (James et al., 2016) found that 40% of TGNC individuals reported a past suicide attempt, which is nearly nine times the rate of the general population of the United States.

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Moreover, suicide rates were highest among those 18 to 24 years of age, with 41% of those in this age range reporting a past suicide attempt. Twenty-six percent of the respondents reported that their most recent suicide attempt occurred between the ages of 14 and 17 (James et al., 2016). Similarly, reports from specialized pediatric gender clinics and community samples have demonstrated rates of attempted suicide, suicidal ideation, nonsuicidal self-injury, depression, anxiety and psychiatric histories that exceed those found among the general population (Olson, Schragger, Belzer, Simons, & Clark, 2015; Reisner et al., 2015; Spack et al., 2012).

The elevated rates of mental health problems among TGNC youth should not be attributed to being TGNC per se, but are thought to be related to the ongoing experiences of discrimination, marginalization, rejection, and isolation that TGNC youth face. The Minority Stress Model posits that sexual minorities experience chronic stress related to discrimination, prejudice, and conflicts between one's affirmed, true self and the expectations of one's social, cultural, and political environments (Meyer, 2003). This stress then contributes to the development of emotional and psychiatric problems. In formulating the Gender Minority Stress Theory, Hendricks and Testa (2012) have applied Meyer's (2003) theory to TGNC individuals. The Gender Minority Stress Theory explicates ways in which overt discrimination and rejection, anticipated fears of discrimination and rejection, and internalized transphobia may be related to the development of emotional difficulties, particularly suicide risk (Hendricks & Testa, 2012). Importantly, the authors note that Gender Minority Stress Theory provides us with the opportunity to identify sources of resilience among TGNC individuals. In particular, the authors emphasize Meyer's (2003) suggestion that "group level coping" can act as a buffer against or method of healing from gender minority stress (Hendricks & Testa, 2012). As such, the authors recommend that clinicians help TGNC individuals find opportunities to connect to and share resources with one another (Hendricks & Testa, 2012).

Examples of overt factors leading to gender minority stress include family rejection, gender-based discrimination, and social isolation, all of which are particularly endemic among TGNC individuals (e.g., James et al., 2016). Consistent with the Gender Minority Stress Theory, all of these experiences have been found to be associated with significantly higher rates of mental health symptoms among TGNC youth and young adults. There are positive associations between parental rejection and suicidality, depression, substance use, and homelessness (Bauer, Scheim, Pyne, Travers, & Hammond, 2015; Grossman and D'Augelli, 2007; Simons, Schragger, Clark, Belzer, & Olson, 2013). Social isolation and loneliness have also been found to be associated with suicidality among TGNC

youth (Bauer, Scheim, et al., 2015; Testa, Jimenez, & Rankin, 2013). Research has linked gender-based victimization to suicidality, depression and low self-esteem (Bauer, Scheim, et al., 2015; Clements-Nolle, Marx, & Katz, 2006; James et al., 2016). Last, several recent studies have found associations between internalized transphobia and suicidal behaviors (Bauer, Scheim, et al., 2015; Perez-Brumer, Hatzenbuehler, Oldenburg, & Bockting, 2015).

It is important to acknowledge that the meaning and experience of gender nonconformity may vary based on other aspects of identity such as race, ethnicity, income level, religion, or sexual identity. The theory of intersectionality proposes that aspects of one's identity do not exist in isolation; rather, aspects of one's identity interrelate in complex ways that then impact one's level of privilege, experience, or perception in society (Crenshaw, 1989, 1991). For example, TGNC individuals of color, who inhabit multiple marginalized identities, may experience discrimination or marginalization on multiple counts, leading to an intensified experience of minority stress and, subsequently, even greater health disparities. Indeed, TGNC individuals of color are more likely to attempt suicide than TGNC individuals identifying as Caucasian (James et al., 2016; Perez-Brumer et al., 2015). TGNC women of color are at higher risk for discrimination, abuse, and HIV infection (James et al., 2016; Wilson et al., 2015). There is significant consensus that clinical interventions must address the impact of intersecting minority identities on the TGNC experience (Connolly, Zervos, Barone, Johnson, & Joseph, 2016; Reisner et al., 2016).

Disparities in Access to Affirmative Care

TGNC individuals have difficulties finding affirmative medical and mental health services. Research has found that 33% of TGNC individuals report having a negative experience with a health care provider in the past year and 23% report postponing necessary medical care due to fears of discrimination (James et al., 2016). Other research has found that TGNC individuals express a lack of comfort discussing their TGNC identity with their primary care health providers (Bauer, Zong, Scheim, Hammond, & Thind, 2015). This is particularly problematic given the fact that medical transition has been linked to improved mental health functioning and overall life satisfaction (Bauer, Scheim, et al., 2015; de Vries et al., 2014). Concerns about discrimination, stigma, and past experiences with gender-invalidating care also prevent young people from reaching out for mental health care (Benson, 2013; Grossman & D'Augelli, 2006; Hendricks & Testa, 2012; Herbst et al., 2008). Despite these concerns, the field continues to experience a lack of avenues for specialized or in-depth training in the areas of gender-affirming care, with only one quarter of psychology graduate students believing they are "sufficiently familiar"

with issues related to TGNC care (American Psychological Association [APA], Task Force on Gender Identity and Gender Variance, 2009).

In response to the lack of available care for TGNC individuals, there has been recent growth in the number of interdisciplinary gender clinics nationwide (Edwards-Leeper et al., 2016; Hsieh & Leininger, 2014; Sherer et al., 2012). As such, the field of TGNC care has continued to evolve and recommendations on best practices have begun to emerge. Experts have begun to provide guidance on (a) the development and course of gender dysphoria; (b) evaluation protocols for hormone therapy; (c) medical guidelines for transition services; (d) guidance for parents on navigating gender transitions; and (e) the importance of interdisciplinary care (de Vries & Cohen-Kettenis, 2012; Edwards-Leeper et al., 2016; Hidalgo et al., 2013; Menvielle, 2012; Vance, Ehrensaft, & Rosenthal, 2014; Olson, Forbes, & Belzer, 2011).

A Model of Integrated Care

Expanding on what already exists in the literature, we present a comprehensive, integrated approach to addressing the mental health disparities among TGNC youth. Mental health disparities faced by TGNC youth are multidetermined. As such, interventions should be multifaceted and integrated. Provision of evidence based practice that has been tailored to the specific needs of marginalized populations is an essential aspect of addressing mental health disparities (American Psychological Association [APA], 2015; Austin & Craig, 2015). Cognitive-behavioral and dialectical behavior therapy (DBT) have significant empirical support for treating the types of emotional distress—such as depression, anxiety, suicidality, and self-harm—that result from discrimination, rejection, and gender invalidation (Compton, March, Brent, & Curry,

2004; Kliem, Kroger, & Kosfelder, 2010). As such, we apply gender-affirming CBT and DBT throughout our practice. In the presentation of our model, we describe how we intervene at multiple levels and how we weave gender-affirming, cognitive behavioral, and dialectical behavior practices through our levels of intervention. The description of our interventions are grouped into three levels of service: macro-level interventions, mezzo-level interventions, and micro-level interventions. In the section on micro-level interventions, we detail how we have embedded gender-affirming CBT and DBT into our ecosystemic model of care. Case examples represent composites based on our experience, not actual cases.

Since its inception in 1968, the Mount Sinai Adolescent Health Center (MSAHC) has been providing no-cost, comprehensive, and confidential care to individuals between the ages of 10 and 24. In 2012, we revised our services to improve care for TGNC youth. Since this time, we have served approximately 500 of these young people. Our program includes a wide variety of integrated services under one roof (Table 1).

Macro-Level Interventions

Macro-level interventions address the effects of policies as well as sociocultural and political contexts on a patient population. While the bulk of our interventions are provided at the mezzo- and micro-levels, we make targeted efforts to intervene in the policies and sociocultural contexts impacting TGNC youths’ lives.

Creating Social Change Through Informing Policy and Best Practices

Transphobic discrimination occurs in multiple contexts of youths’ lives, such as schools, medical centers, the workplace, and social welfare agencies. Many antidiscrimination

Table 1
The Range of Disciplines, Professionals and Services Provided in the MSAHC Integrated Transgender Health Service

Discipline	Types of Professionals	Services Provided
Medical	Adolescent Medicine Specialists	Primary medical, reproductive and sexual health care Medical evaluations for and provision of puberty suppression and cross-gender hormones
Mental Health	Psychiatrists Clinical Psychologists Clinical Social Workers	Individual therapy Family therapy Evaluations for Hormone Therapy Psychiatric Evaluations and Medication Management Comprehensive Psychological Assessment Parent Support Groups Youth Support Groups Social activities and trips
Health Education	Health Educators	General and transition-related case management
Legal support and Advocacy	Paralegal Lawyer	Reproductive health education and counseling General and transition-related legal support and advocacy (e.g., name changes, school advocacy)

policies do not include protections for TGNC identities (National LGBTQ Task Force, 2013), and existing policies are not always enforced. Using school as an example, a recent national survey of 10,528 students between the ages of 13 to 21 found widespread transphobic and discriminatory behavior in schools. The majority of TGNC students reported being prevented from using the pronouns or bathrooms that align with their gender identity and verbal and physical harassment were found to be commonplace (Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016). These experiences are associated with increased rates of mental health problems, while institutional efforts to promote fair treatment of and equal rights for TGNC youth are associated with decreased rates of psychological distress for TGNC youth (Greytak, Kosciw, & Boesen, 2013; Kosciw et al., 2016).

In accordance with American Psychological Association (APA) guidelines for working with TGNC individuals and the Society for Adolescent Health and Medicine (SAHM) recommendations for working with LGBT youth (APA, 2015; SAHM, 2013), we strive to create social change by informing public policy and best practices. We regularly present to multidisciplinary audiences (e.g., medical and mental health professionals, lawyers, educators, advocates) at local, regional, and national conferences on best practices in providing gender-affirming care to TGNC youth and young adults (e.g., Steever, Oransky, & Barangan, 2016). In so doing, we distribute tools we have developed to provide gender-affirming care. In addition, we consult with and provide guidance to other local, state, and national medical, educational, and child welfare agencies as they make policies and protocols related to the treatment of TGNC individuals. For example, we have worked with child welfare agencies in determining their policies on providing gender-affirming medical and psychosocial interventions to TGNC youth. In addition, we have consulted with national medical associations as they make guidelines for TGNC health care.

Direct Advocacy

We intervene in the various systems of young people's lives in order to help respond to incidents of transphobic discrimination. While these interventions contain aspects of micro-level interventions (e.g., "in-the-room" interventions), they often result in a more systemic change. Using schools as an example, we take the following steps to intervene in transphobic discrimination: (a) determine with our patients if their affirmed gender is being respected (e.g., use of name, use of pronouns, use of bathroom); (b) assess with patients if they are experiencing gender-based victimization in school; and (c) if patients are not out at school, help them assess the safety of coming out. If a patient is experiencing gender-based discrimination, we

will (a) educate them on the rights of TGNC students; (b) help them decide if they would prefer to advocate on their own behalf or if they would like our direct involvement; and, if they would like our direct involvement; (c) contact school personnel to educate them on aspects of the TGNC experience, the rights of TGNC students, and the impact that gender-based discrimination can have on students' well-being. We then discuss with the school personnel ways of creating a safe space for this student and all TGNC students. These direct-advocacy efforts can, at times, lead to more systemic changes through the clinician's further involvement in the specific system of care (e.g., helping the school better follow or implement gender-affirming policies).

Case Example

Daisy is a 15-year-old TGNC female who just started the ninth grade at a NYC public high school. Daisy's parents are supportive but Daisy is worried about sharing her TGNC identity at school. The school personnel are supportive and aware of local policies for working with TGNC students. However, they have never had a TGNC student at their school. Daisy has made friends in school, but is afraid she will be rejected if she comes out. Daisy uses the girls bathroom, but doesn't feel comfortable changing in the girls locker room and uses the principal's bathroom to change. Her friends are starting to ask questions about this and she is failing PE because she has stopped changing clothes. Teachers were made aware that they should not use Daisy's birth name while calling attendance, but every time there is a substitute teacher, Daisy has a panic attack when attendance is called. When the school has an overnight trip, the principal is worried about allowing Daisy to dorm with the other girls.

Daisy's therapist advocates for Daisy to obtain her PE credits at a local recreation center. Daisy came out to two of her closest friends, who were supportive. Her therapist advocates for her to go on the overnight trip and stay in a room with these two friends. Daisy's therapist gave her parents information for a local legal advocate who is assisting the family in getting Daisy's legal name and gender marker changed. In the meantime, the therapist was also able to advocate with the school for Daisy's name to be changed on the attendance rosters. Following this, a school official asks Daisy's therapist to present to an audience of teachers and other school personnel on best practices in working with TGNC students.

This example demonstrates how clinicians can intervene so that systems are more responsive to the needs of TGNC clients. Daisy's therapist used her expertise to make systems-level interventions on her behalf. These interventions helped create a more validating environment for Daisy and other students.

Name and Gender Marker Changes

Many TGNC youth hope to legally change their name and gender markers on identification cards so that their legal identities match their lived experiences. Those who are unable to obtain name and gender marker changes may face difficulties when applying to school, to jobs, for public benefits, and for health care. Research among TGNC individuals has found an association between having one's identification documents match one's gender identity and being at lower risk for suicide (Bauer, Scheim, et al., 2015). We act as advocates in helping youth obtain identifications that match their gender identities (APA, 2015). Our program has an on-site legal team (one paralegal and one lawyer) that works exclusively with our patients. We educate patients on the process of obtaining legal name and gender marker changes and then assist them in making these changes, including accompanying them to court. Building a partnership with a legal advocate who has experience in this process will aid health centers in providing a valuable service to TGNC youth.

Mezzo-Level Interventions

Mezzo-level interventions are those that impact the structure of the clinic, clinic procedures, and general environments of care. TGNC youth are less likely to seek medical and mental health care due to negative or invalidating experiences with service providers (Benson, 2013; Clark et al., 2014; Grossman & D'Augelli, 2006). In addition, they may be unsure about how to access care or be constrained by financial difficulties or a lack of caregiver support. We have found that the following clinic structures and policies create an affirming, welcoming, and easily accessible care environment.

Removing Barriers to Care

First, low-income and uninsured TGNC individuals are less likely to obtain access to both medical and mental health care (James et al., 2016). All of our care is provided regardless of ability to pay. Fundraising and grant money cover the cost of care for youth without insurance. Second, as allowed by New York State laws, we afford adolescent minors the right to seek out their own confidential care, including some medical and most reproductive health services and mental health services without which their well-being may be endangered. Third, as described throughout this article, our program offers many services (e.g., family therapy, support groups, individual therapy, medical transition services). TGNC youth can enter our program by signing up for one specific or any number of services, allowing them to enter the program through many avenues. For example, some youth choose to obtain only medical services and can do this by simply

making an appointment with a medical provider. Other youth may initially join our support group (by contacting the clinician who runs the support group) and then, for example, obtain an internal referral to other services (e.g., individual therapy). Allowing young people to determine how and when they would like to access each service creates many entry points into our program, further reducing barriers to accessing care. Fourth, concerns about discrimination, stigma, and past experiences with gender-invalidating care may prevent young people from reaching out for both medical and mental health care (Bauer, Zong, et al., 2015; Benson, 2013; Grossman & D'Augelli, 2006; Hendricks & Testa, 2012; Herbst et al., 2008). In order to address this barrier, we have created connections and partnerships with schools, youth programs, and community centers that cater to and have built trust with TGNC youth communities.

Clinic Environment, Procedures, and Forms

We strive to give the clinic environment and waiting room a TGNC-affirmative and welcoming atmosphere. In order to increase the comfort of TGNC youth and create an inclusive environment, the art and informational posters on the walls of the clinic have been evaluated so that all youth see themselves represented in the information on the bulletin boards. Many of the clinical staff have "safe zone" stickers or signs in their offices or similar types of ribbons or pins on their ID badges or lab coats (APA, 2015; Lev, 2009). In accordance with APA guidelines for transgender care (2015), all intake forms, paperwork, and patient questionnaires include a space for "preferred name" and a "transgender" option in the gender category. For any type of visit, patients can write "preferred name" on the registration form so that staff do not use a TGNC patient's birth name when calling them for their appointment. This preferred name can also be flagged in the electronic medical records so that any provider opening the patient's chart is immediately alerted. In order to increase their comfort in our institutional setting, youth are invited to use the bathroom that most fits with their gender (Transgender Law Center, 2005). Of note, some youth have recently voiced frustration with the phrasing "preferred name," as it implies that the name is a preference rather than their true or affirmed name. In response, we are currently reviewing alternative phrasing with input from TGNC youth.

Trainings and Supervision

Trainings in gender-affirming care were initiated with the entire staff at the MSAHC. This commenced with two, 2-hour trainings with the staff, which were then followed by discipline-specific trainings (APA, 2015). We hold routine group supervision for mental health clinicians working

most closely with TGNC youth in order to increase skills and knowledge and to help clinicians reflect on and manage any biases related to cisgender privilege (American Counseling Association, 2010; APA, 2015). In order to ensure a welcoming and affirmative environment, our nonclinical, registration staff are trained to be sensitive to the experience of TGNC patients. The coordinators of TGNC services make themselves available for follow-up questions from any staff member.

We also strive to train the next generation of adolescent medical and mental health care providers in gender-affirming care. Research indicates that TGNC individuals have difficulty accessing gender-affirming medical and mental health providers (e.g., Bauer, Zong, et al., 2015; Grossman & D'Augelli, 2006) and that, despite this, few training programs specialize in this area (APA, 2009). Our training programs for adolescent medicine physicians and psychology doctoral students provide comprehensive training in how to provide gender-affirming care. We cross-train our trainees so that they graduate understanding TGNC care from an interdisciplinary perspective (Edwards-Leeper et al., 2016). Training for psychology interns emphasizes the use of gender-affirming CBT and DBT, as described in later sections.

Integrating Care Across Disciplines

Integrated, interdisciplinary care has become the recommended best practice when working with TGNC individuals (APA, 2015; Edwards-Leeper et al., 2016). Integrating services ensures that patients are more likely to follow through on referrals from one discipline to another. In our center, all of the disciplines and professionals listed in Table 1 work together in the same building and interact on a regular basis. TGNC youth can access any or all of the services listed. In addition to co-locating all services, we take a number of practical steps to make sure that our services remain integrated: mental health and medical protocols are developed in tandem, with one discipline weighing in on the other's protocol; we hold regular meetings between the coordinators of the mental health and medical services; mental health clinicians can attend their patients' medical visits; mental health clinicians attend their patients' meetings with legal advocates; and the electronic medical records are shared across disciplines.

Micro-Level Interventions

Micro-level interventions are conceptualized as “in the room” therapeutic practices. We employ micro-level interventions aimed at creating a safe space, targeting family rejection, implementing gender-affirming DBT and CBT, providing supportive group interventions, and facilitating transitions.

Setting the Stage: Sharing Our Gender Affirmative and Social Justice Perspective

Many TGNC youth arrive to therapy distrustful that they will be pathologized or that therapists occupy an adversarial position—standing between them and the medical interventions they desire. They may be reticent to divulge information due to past experiences of discrimination or fears of being denied medical interventions due to mental health problems (APA, 2015; Hendricks & Testa, 2012). We draw from feminist and multicultural psychology approaches, as well as the minority stress model, all of which inform us that oppressed and marginalized individuals are at increased risk for mental health issues due to the discrimination they experience (Brown, 1994; Goodman et al., 2004; Meyer, 2003). The survival responses (e.g., being guarded) that many clients develop under these stressful situations are often mistaken for pathology (Brown, 1994; Goodman et al., 2004). While we recognize that objectivity is impossible and some amount of bias is inevitable, we work hard to recognize how these factors, as well as the power and privilege inherent in our roles, inform our treatment (Edwards-Leeper et al., 2016; Goodman et al., 2004; Hendricks & Testa, 2012).

Drawing from these traditions, and in line with contemporary gender-affirming approaches (APA, 2015; Edwards-Leeper et al., 2016; Hendricks & Testa, 2012; Hidalgo et al., 2013), we employ the following strategies. We are immediately up front about our gender-affirming and social justice perspective. This entails sharing the following information in our initial sessions: gender variance is a normal part of the human experience; individuals have the right to self-determination in defining their own identities; our goal is to help clients live as their authentic selves; and (if this applies) as cisgender people we understand that we have never had to prove our gender to anyone (Edwards-Leeper et al., 2016; Goodman et al., 2004; Hendricks & Testa, 2012; Hidalgo et al., 2013). In addition, we acknowledge up front that youth may be reluctant to be fully open with us for fear that they will later be denied letters of support for medical interventions (Hendricks & Testa, 2012). We strive to be transparent during the initial stages of treatment and explain to youth that significant histories of psychiatric difficulties, victimization or experiences of internalized transphobia do not preclude letters of support for medical transition. Laying this framework in the first session can begin to build an atmosphere of comfort and trust.

We also provide up-front psychoeducation about and assess for the impact of transphobia (APA, 2015; Hendricks & Testa, 2012). We review evidence that, for many TGNC people, mental health symptoms are rooted in experiences of discrimination, isolation, and lack of

support. For those who have endured more serious abuse, we provide education on, validate, and address symptoms of posttraumatic stress. It is important to provide this psychoeducation initially, as many youth will blame themselves for their symptoms.

Finally, in order to attend to and challenge our own potential biases, we hold weekly TGNC-focused group supervision sessions for clinicians-in-training and monthly group supervision sessions for more experienced clinicians. In addition, we actively teach about and ask clinicians to discuss their own cisgender privilege and ways in which it may be affecting their clinical work. Last, we attend conferences and trainings to keep updated on new treatment protocols and trends that are emerging in the field (e.g., medical interventions for nonbinary youth).

Family Therapy and Parental Guidance

Given the growing evidence that caregiver rejection is linked to mental health disparities among TGNC youth (e.g., suicidality, depression, homelessness), we place great focus on promoting family acceptance (Grossman and D'Augelli, 2007; Simons et al., 2013). In framing our interventions, we draw from Malpas' (2011) Multi-Dimensional Family Approach (MDFA), which incorporates the use of separate but interconnected therapeutic modalities, including parental education and coaching, child assessment and therapy, family therapy, and parent support group. In addition to adapting this multimodal way of working with families, we draw from the major therapeutic goals of MDFA, which include (a) helping both the child and caregiver(s) to balance the youth's affirmed and authentic gender identity with the social realities of a binary and/or transphobic world, and (b) repairing disrupted bonds that have occurred as a result of tension over the youth's gender identity or expression. Achieving these goals often involves significant work with caregivers in terms of exploring their own conceptions of gender and their desires to protect their children from discrimination and harm (Malpas, 2011). In addition, we draw from Ryan's (2009) work with the Family Acceptance Project, which emphasizes educating families and caregivers about the impact of acceptance and rejection behaviors on the mental health of TGNC youth.

Caregiver Guidance

Caregivers, especially those who are unsupportive, are often wary that we will have a "transgender agenda"—that we are somehow motivated to see all gender-questioning youth as transgender and will automatically guide all youth toward transitioning. We meet this fear head-on. After validating their concerns, we explain that our primary goals are (a) to work on reducing major mental health symptoms, (b) to help the young person explore

and understand their identity, (c) to help the young person live authentically as their true self—whatever that may be, (d) to understand how the young person's current experiences are impacting family members, and (e) to increase communication between family members. In general, we have found that approaching unsupportive caregivers with curiosity and concern, rather than confronting them with corrective education, enables them to move toward acceptance (Malpas, 2011).

In initial sessions with caregivers, we start by assessing what kind of information the caregivers have on the TGNC experience ("What has your child told you about their gender?" "What have you learned about this on your own?"). We listen carefully to and validate caregivers' fears, which often take the form of: "My child is choosing such a hard life"; "My child will never be safe"; "They are way too young to know"; "People will see them as a freak"; and "I've failed as a parent." We validate caregivers' fears, sympathize with their anxieties and also provide gentle, initial psychoeducation ("People of all gender identities find significant others" and "It is highly unlikely for parenting practices to have influenced your child's gender identity"). Ongoing parental guidance consists of providing psychoeducation and helping caregivers modify unsupportive behaviors. We also explore caregivers' conceptions of gender and what historical, familial, or cultural meanings they have attached to gender (Malpas, 2011; Menvielle, 2012). We explore how gender identity intersects with various other identities, such as race, ethnicity, sexual identity, religion or class. Through understanding their own conceptions and biases about gender, coupled with psychoeducation about gender, unsupportive caregivers typically become more open to examining their behaviors (Malpas, 2011; Menvielle, 2012).

We have found family sessions to be particularly powerful in helping increase caregiver support. Caregivers often feel blindsided by youth coming out as TGNC and react in ways that feel unsupportive to youth. In turn, the young person will shut down and provide little information to their caregivers. Consequently, caregivers feel shut out and dig into their resistant stance. Our goal during family sessions is to undo this process. We typically have the youth explain their gender identity to their caregivers and how this identity has evolved over time. In addition, we help youth to explain their experience of gender dysphoria and the pain and distress that this can entail. In our experience, caregivers are often surprised by how clearly young people can articulate their gender identity and the acuity of the pain related to gender dysphoria. We often help young people talk about how daily experiences of, for example, being misgendered by their caregivers can be painful and feel rejecting (Ryan, 2009). When caregivers witness their children's pain, they

often begin to more seriously reflect on and modify their behaviors. Finally, we help caregivers and youth understand that some unsupportive behaviors (e.g., not letting a male-bodied child leave the house in a dress), are the product of caregivers' concerns about safety (e.g., my child will get harassed; Ryan, 2009). Caregivers and youth then work together to negotiate the tension between the youth living authentically and the caregivers' safety concerns (Malpas, 2011).

Case Example

Archie, a biracial (African American and Caucasian) 15-year-old TGNC male, was brought into the clinic by his parents. His parents were hoping we could run tests to see if he was "really" TGNC. They wanted to know if we could provide him with more estrogen so that he felt as though he was a girl. They were worried that his insistence on being male was another "phase" in a long line of specific and intense interests. Archie was tearful, expressing intense gender dysphoria, even admitting to passive suicidal ideation. He was shut down in sessions with his family and had ceased communicating with them at home.

Archie's mother was a proud feminist from a socially conservative African American family, who had become a community leader around issues of women's rights. Given her progressive politics, Archie was surprised that his mother was not more supportive of his desire to transition. As the family therapist guided Archie's mother through an exploration of her beliefs about gender and how these had been shaped through her family and cultural history, Archie's mother came to understand the following: Raising a strong, empowered African American daughter was part of her identity as an African American feminist. She felt a deep sense of loss and betrayal that her child was "choosing to join the patriarchy" rather than carry on what she saw as her ideals as a feminist leader. Archie's father was from a Caucasian, working-class background and had worked hard to achieve upward economic mobility and provide what he saw as hardship-free life for his child. He could barely stomach the idea that his child would "choose" a life that could lead to increased hardship and pain.

Once his parents had a better understanding of their rejecting behaviors, Archie began meeting with them for family sessions. He was initially hesitant to be vulnerable, but recognized that it was necessary for his parents to understand what he was going through. The pivotal moment in family sessions came when Archie explained his experience of gender dysphoria in an emotionally resonant way. He explained to his parents how calling him "she" felt like "being stabbed with a dagger." His parents saw his pain for the first time. They began to worry more about his suicidality than their fears of transitioning. One year after starting therapy, Archie's parents allowed him

to begin hormone therapy and, soon after, his suicidal ideation resolved.

This case example illustrates how caregivers' rejection of their TGNC youth can be rooted in the meaning they assign to gender; how increased communication on the part of a young person can lead to increased understanding on the part of caregivers; and how helping parents modify rejecting behaviors can increase familial harmony. In the end, family therapy can be vital in helping youth live as their authentic selves, leading to a reduction in serious distress.

DBT

Given the disproportionate rate of suicide attempts, suicidal ideation, and self-harm behaviors among TGNC adolescents and young adults (James et al., 2016; Olson et al., 2015; Reisner et al., 2015; Spack et al., 2012), it is imperative that we develop TGNC-sensitive methods of adapting empirically supported therapies for chronic suicidality. DBT has demonstrated empirical support for treating suicidality and self-harm in adults and adolescents (Kliem et al., 2010; Mehlum et al., 2014) and is an important tool that we use to address suicidality and self-harm with TGNC youth. Similarly, Sloan, Berke, and Shipherd (2017) have recently described how the DBT framework can be used to understand and address clinical distress among TGNC individuals. At MSAHC, we offer adherent, full-model DBT, including individual sessions, skills group training, phone consultation, and consultation team (Linehan, 1993). Some of the ways in which we tailor DBT to TGNC youth are described below.

DBT Theoretical Suppositions and Psychoeducation

The theoretical framework behind DBT posits that chronic emotion dysregulation, self-harm, and suicidality develop, in part, through growing up in an "invalidating environment" (Linehan, 1993). Within this theory, an invalidating environment is defined as an environment that rejects, negates, or ignores an individual's expression of internal experiences (Crowell, Beauchaine, & Linehan, 2009). For many TGNC youth, this "invalidating environment" may consist of the experience of family, community, and society-wide transphobia and discrimination and daily experiences of gender invalidation (e.g., being misgendered), and is similar to the factors contributing to the experience of gender minority stress (Hendricks & Testa, 2012; Sloan et al., 2017). Youth receive psychoeducation about how years of gender invalidation and experiences of having their gender dysphoria dismissed, ridiculed, or punished can lead to significant problems with emotion regulation through the accumulation of upsetting emotions, a lack of validation regarding the upsetting nature of these experiences and the failure to build adaptive skills to manage these feelings (Linehan,

1993). Many of the TGNC youth we have worked with respond well to and find comfort in this psychoeducational process. Indeed, many of the TGNC youth we work with who reside in invalidating environments experience their emotions as distressing and difficult to manage. They have internalized pathologizing messages that their emotional dysregulation is caused by problems internal to them. Elucidating the invalidating impact of transphobic environments, and how this chronic invalidation can lead to emotional dysregulation, helps them locate their difficulties within a dominant culture of pervasive gender invalidation (Sloan et al., 2017), ultimately decreasing feelings of shame and guilt associated with their emotional dysregulation. A second tenet of DBT that can be helpful with TGNC youth is the dialectic of acceptance versus change (Linehan, 1993). This framework can help youth to acknowledge and accept their current pain (e.g., gender dysphoria, family rejection) while simultaneously working toward change (e.g., finding ways to transition and building community; Sloan et al., 2017).

DBT Skills Training

Many DBT skills are applicable to TGNC youth struggling with suicidality and self-harm. One of the main considerations in providing DBT in a gender-affirming fashion is to acknowledge common triggers to emotional dysregulation or distress: being misgendered, outright rejection, gender/body dysphoria and hopelessness about transitioning. Once these triggers have been identified, youth can apply DBT skills to manage the resultant distress.

The use of “Wise Mind,” from the “mindfulness” module, which encourages the integration of logical reasoning (“reasonable mind”) and emotional reactions (“emotion mind”) (Linehan, 2015), is useful in helping youth manage their hopelessness about being able to transition. Many youth respond to their inability to transition (typically due to lack of consent from family) with emotion mind: They feel rejected, invalidated, angry, and despairing, and this can lead to self-harm or suicidal behavior. Helping youth integrate “reasonable mind” into this reaction enables them to call on thoughts such as “I can transition when I am 18” or “lots of people’s parents change their minds.” For example, using Wise Mind has enabled some youth that we work with to come to resolutions such as the following: “I am really hurt and upset that I can’t transition now and I know that I will be able to in the future. I can manage my feelings now so that I can live authentically when I am older.” Distress tolerance skills, another module of DBT skills, are essential for TGNC youth dealing with self-harm and suicidal behavior. These skills aid TGNC youth in tolerating distressing affect states without engaging in self-harm. Distress tolerance skills, such as the ability to

distract oneself or self-soothe, enable youth to maintain safe coping strategies when they are invalidated, particularly by important others (e.g., caregivers).

Another module of skills taught in DBT is emotion regulation skills (Linehan, 2015). Emotion regulation skills help TGNC youth to understand the basis of difficult emotions in the context of gender dysphoria or gender invalidation and how to reduce or manage these emotions (e.g., coping skills, gender transition or finding supportive communities). An important skill taught in the emotion regulation module—“coping ahead”—can be used to help TGNC youth to anticipate and plan coping strategies for the emotional consequences of coming out or transitioning (Sloan et al., 2017). Another skill set taught in DBT is interpersonal effectiveness skills (Linehan, 2015). TGNC youth often struggle to be gendered correctly by others, to be called by their affirmed names (as opposed to their birth names), or to gain permission to use the school bathroom that aligns with their true gender. Given histories of invalidation, in addition to ongoing fears of rejection, many youth have trouble advocating for their rights. The interpersonal effectiveness skills module in DBT teaches youth the skills to get their needs met through effective communication (Linehan, 2015). Indeed, a number of the youth we have worked with have effectively used these skills in order to get their names changed on attendance rosters or to obtain permission to use school bathrooms that are consistent with their true gender.

Case Example

Jack was a 16-year-old Latino transgender male who came to our clinic seeking mental health and transition-related services. Jack presented to therapy with a long history of self-harm, two past suicide attempts, and a history of aggressive outbursts. Jack demonstrated severe emotion dysregulation underlying his behavioral symptoms.

Through DBT’s psychoeducation phase, Jack came to understand that growing up in a transphobic environment and experiencing gender invalidation had contributed to problems with emotion regulation. He described living in a state of constant fear that he would be referred to as “she” or that his parents would rescind support for his transition. Jack drew comfort from the idea that his emotional dysregulation was not purely the result of a pathology internal to him. In addition, Jack experienced body dysphoria, reporting acute distress when he saw his naked body, menstruated, or heard his own voice. A pattern with Jack was clear. His self-harm and suicidal ideation were triggered by experiences or fears of being misgendered, hopelessness about his transition, and body dysphoria. He initially used DBT’s distress tolerance skills focused on changing his physiological state (e.g., holding ice; intense exercise) to prevent self-harm or aggressive

outbursts. Over time, Jack developed DBT-based skills that directly counteracted his triggers: self-talk to counteract hopelessness about transitioning; interpersonal effectiveness skills to correct those who were misgendering him; “coping ahead” to manage body dysphoria (e.g., wearing a bathing suit in the shower); and “opposite action” to manage aggressive urges toward his parents. After 1 year in DBT, Jack ceased to engage in self-harm behaviors or to experience suicidal ideation.

This case example illustrates how the DBT case conceptualization can be tailored to the unique experiences of TGNC youth. Jack’s emotional dysregulation was related to ongoing experiences of gender invalidation and gender dysphoria. Once specific triggers to his dysregulation were identified, DBT skills were effective at helping him manage and, ultimately, reduce his most destructive behaviors.

CBT

CBT has demonstrated impressive evidence for alleviating symptoms of depression and anxiety (Compton et al., 2004). At the same time, empirically supported treatments often need to be tailored to meet the needs of specific populations or cultural groups, such as TGNC youth (Austin & Craig, 2015). We employ the following strategies with TGNC youth.

Challenging Transgender-Specific Negative Beliefs

Developing in a largely transphobic environment can lead youth to internalize negative messages about themselves, their worth, and their possibilities for future happiness and success (Austin & Craig, 2015; Hendricks & Testa, 2012). Similar to Austin and Craig’s (2015) work with Transgender Affirmative Cognitive Behavioral Therapy, we employ strategies to help youth (a) identify negative self-beliefs, (b) understand how these beliefs lead to symptoms of depression, anxiety, and low self-esteem, (c) tie these beliefs to messages they have heard about TGNC individuals, (d) find evidence to disconfirm these beliefs, and (e) build new, more positive beliefs about themselves. It is not uncommon for the youth we work with to have core negative beliefs about their deviance (“There’s something wrong with me”) or their future (“I’ll never be happy because of who I am”). Strategies to combat such messages include helping youth find examples of happy and successful TGNC individuals, connecting them to peer social supports, and helping them see how these beliefs stem from rigid and discriminatory conceptions of gender.

Of note, it is important to be culturally sensitive when challenging belief systems that pathologize TGNC identities. We have had several religiously observant clients (and many parents), for example, who found great meaning in the same belief systems that viewed them as

deviant. Challenging these belief systems outright did not work as well as taking a more gentle or curious approach that acknowledged the nuance and contradictions at hand.

Support Groups, Social Activities, and Community Building

Disconnection and social isolation are risk factors for depression, suicidality, and homelessness among transgender youth (Bauer, Scheim, et al., 2015; Testa et al., 2013). At the same time, Hendricks and Testa’s (2012) Gender Minority Stress Theory asserts that connection with and support from other TGNC individuals may be one of the most important sources of resilience. Indeed, qualitative research with TGNC individuals of color has found that building community with other TGNC individuals provides a source of strength and healing, with one study demonstrating that community can be built within a community health clinic setting (Pinto, Melendez, & Spector, 2008; Singh, 2013; Singh & McKleroy, 2011). In addition, group interventions are an effective medium through which children and adolescents can learn and build effective, cognitive behavioral coping skills (Clarke et al., 2001; Liber et al., 2008). As such, one of the most important psychosocial interventions we have provided TGNC youth is a peer community through which they can receive support and build effective coping skills.

We run weekly groups that are focused on accomplishing the following goals: (a) creating a safe and supportive environment that allows youth to present as their affirmed gender; (b) fostering supportive relationships that increase a sense of belonging; (c) providing peer education and support on topics such as medical and social transition, dealing with family rejection, and accessing legal resources and community supports; and (d) building effective, cognitive-behavioral coping skills to deal with symptoms of depression, anxiety, low self-esteem and isolation. Importantly, coping skills are taught by both group facilitators and by peers. In addition to running weekly support groups, we hold regular events focused on accessing TGNC-themed media (e.g., movie screenings); socializing and creating community (e.g., holiday parties); and social transitioning (e.g., makeup tutorials). This community space has been particularly integral in supporting youth who are rejected by their families.

Case Example

Kate is an 18-year-old multiracial transgender female who had a long history of physical abuse and neglect from her mother and her mother’s boyfriends. Kate was forced to leave home at age 18. The lack of support in Kate’s life put her at risk of ongoing mental health problems, risky behaviors, homelessness, and revictimization. Connecting Kate to our group program was integral in helping her

build a support system. Through the group program, Kate got advice from peers about accessing hormones legally and tips on her makeup skills. She received emotional support during times of increased suicidality. In addition, her peers helped her create a “coping skills toolbox” that included deep breathing, behavioral activation, and cognitive restructuring. She received help navigating the shelter system from another group member who had experienced homelessness and, ultimately, found permanent housing through another group member’s family connections. She celebrated holidays with her “chosen family” through our group program’s holiday dinners.

This case example highlights the importance of fostering a sense of connection and building meaningful relationships within a peer community. Through the support group, Kate found a safe and supportive environment, decreased her social isolation, developed a sense of belonging, received advice on hormone treatment and transitioning, and developed a toolbox of CBT techniques to use when she was feeling distressed.

Facilitating Medical and Social Transition

Physically and socially transitioning have been linked to improved mental health outcomes and life satisfaction (de Vries et al., 2014; Olson et al., 2016). However, gender-affirmative care can be difficult for young people to find (Bauer, Zong, et al., 2015; Clark et al., 2014). At the MSAHC, we provide puberty-suppressing and gender-affirming hormone therapies in addition to referrals for gender-affirming surgeries. A description of our procedures for approving and then facilitating medical transition is beyond the scope of this article. Our protocol follows the guidelines set forth by the World Professional Association for Transgender Health (WPATH), which have been described in detail elsewhere (Coleman et al., 2012).

Individual therapy for transgender youth often focuses on helping the client navigate their physical and social transitions. Affirming care involves building a knowledge base of common issues faced in this process. Issues that often arise include the following: pacing of the transition; social consequences that may arise due to transitioning; managing hopes/expectations for the transition (e.g., voice not changing as much as one hoped; still experiencing gender dysphoria after hormone therapy); and ongoing negotiation with caregivers about aspects of the transition. There are many aspects to the social transition, including but not limited to the following: changes in dress; changes in pronoun use; name change; adopting new mannerisms; using different bathrooms; and coming out at school, to peers, or to various family members. For some youth, each of these decisions requires some thought and planning and can be aided through reflection in therapy and the garnering of support from family members and peers.

Developmental Considerations for Micro-Level Interventions

Our program addresses the needs of young people aged 10 to 24, which represents a broad age range that requires developmental considerations for various micro-level interventions. Group-based interventions that promote community and social support are important for those at risk for gender minority stress (Hendricks & Testa, 2012); however, they may become even more important for youth once they reach mid-adolescence. Starting in mid-adolescence, youth are more likely to look outside of their families for a sense of belonging, identity exploration, and identity formation (Sanders, 2013). On the flip side, we have found that family and caregiver-focused interventions are particularly essential for those aged 10 to 18 and may take a less central role as youth reach majority age. As described above, family acceptance is positively associated with mental health outcomes for TGNC youth (Bauer, Scheim, et al., 2015; Grossman and D’Augelli, 2007; Simons et al., 2013). The beliefs and customs of caregivers are far more likely to influence how a young person navigates aspects of their social and medical transition prior to the age of 18. For example, in many instances, the signature of a legal guardian is required to begin medical transition prior to the age of 18. Intervening in the family system at a young age may promote family-based changes that put a young person on course for a smoother and less treacherous path toward living as their affirmed gender. Best practices for social and medical transitions vary across this age range and a review of these protocols is beyond the scope of this article (for a review see Edwards-Leeper et al., 2016).

Discussion

The core strengths of our program are our ability to intervene at multiple levels in a young person’s life and our use of gender-affirming, evidence-based interventions. TGNC youth face significant health disparities, which are determined by multiple factors. Successful responses must be multifaceted. Our model of care was developed within an established, comprehensive, adolescent-sensitive health care setting that includes a wide range of integrated disciplines and that provides care regardless of ability to pay or insurance status. There are potential barriers to adapting our model, wholesale, to other settings. Other programs may not have this foundation or set of resources from which they can build. Even so, aspects of the model can be adopted in a piecemeal fashion.

In terms of macro-level interventions, medical and mental health clinicians may wish to become involved in efforts aimed at informing policy and best practices for TGNC youth (APA, 2015; SAHM, 2013). For example,

clinicians may choose to give presentations to groups of school officials, medical professionals, or child welfare workers who are endeavoring to improve their current practices and policies related to the treatment of TGNC youth. Clinicians may also wish to apply to present at national conferences that set the tone and social climate for the treatment of patients within their respective disciplines. Furthermore, clinicians can engage in advocacy efforts aimed at writing legal or medical policies. Finally, clinicians are urged to see direct advocacy (e.g., responding to patients' transphobic environments; assisting with name change documents) as part of their routine care when working with TGNC youth (APA, 2015).

In terms of mezzo-level interventions, a practice or health care setting of any size can work, step-by-step, to create a culture or set of clinical and operational procedures that is affirming of TGNC youth. This can begin by displaying a "safe zone" button or sign and can extend to an overhaul of all clinical and operational procedures (e.g., revising documents; training support staff). Guides for making such changes exist (Deutsch, 2016). Integrated care is the best practice recommendation for TGNC youth. While opportunities for fully integrated care may not exist for all programs, this should be thought of as an aspirational goal. One avenue for increasing integration of care is forging connections with local community organizations and/or departments within the same hospital or institution in order to create a network of care (e.g., Sherer et al., 2012).

Offering formal training experiences to mental health and medical students, another mezzo-level intervention, may not be feasible for many programs. However, clinicians or programs with significant expertise in TGNC care are encouraged to approach residency, fellowship, or graduate programs about the possibility of offering a clinical rotation or learning experience in TGNC care. Such learning experiences can start as having one student for one clinical rotation. Finally, providing services at no cost is not an option for most providers or programs, and the inability to generalize that aspect of our model is a limitation of disseminating our approach. However, we raise funds through state grants in addition to grants from private foundations. Applying for such funding may enable other programs to serve additional youth at no cost.

In terms of micro-level interventions, TGNC youth need evidence-based therapies tailored to their unique needs. Of particular import are therapies aimed at addressing suicidality. Programs or therapists specializing in DBT can begin to develop gender-affirming DBT practices aimed at reducing the high rates of suicidality among TGNC youth. Therapists who specialize in working with TGNC youth may benefit from receiving intensive training in DBT. Similar efforts can be made to provide gender-affirming CBT and family therapy. Finally, interventions aimed at increasing a

sense of belonging and community are vital (Hendricks & Testa, 2012). These efforts can start small. Therapists or programs with several TGNC youth can attempt to form a support group with these individuals. We began our first support group this way and, 5 years later, have several, large weekly groups with numerous social events throughout the year. Forging connections with other youth-serving agencies or centers can lead to increased referrals for support or social groups.

Future Directions

Interdisciplinary and gender-affirming care have become best practices for serving TGNC youth. Additional research is needed to continue to evidence the value of such approaches in addition to identifying which components of the integrated model may be most critical. In our clinical practice, we have found that empirically supported interventions—such as DBT and CBT—are vital to addressing the mental health disparities for TGNC youth. In addition to others (Austin & Craig, 2015; Sloan et al., 2017), we have elucidated how these approaches can be tailored to the unique needs of TGNC youth. However, empirical support for gender-affirming DBT and CBT is lacking. More rigorous work is needed to further standardize and then evaluate the efficacy of these approaches (Sloan et al., 2017). Similarly, there are compelling theoretical reasons (Hendricks & Testa, 2012) and qualitative findings indicating the importance of group psychotherapy and programming for TGNC youth (Pinto et al., 2008; Singh & McKleroy, 2011). Additional work is needed, however, to standardize, evaluate, and understand the important factors of group interventions for TGNC youth. Research is needed to understand the role that family therapy can play in reducing the impact of family rejection on mental health disparities for TGNC youth.

Finally, a current limitation to our program that we are working to address is the absence of a common set of data collected on all TGNC patients. In an effort to reduce barriers to care, we allow youth to enter our program in multiple ways (e.g., through attending our support group or making a medical visit). As a result, we do not have a centralized intake process that involves collecting a standardized set of information from all youth. However, in order to better understand the needs of our patients and more effectively describe our outcomes, we are in the process of creating a standardized set of medical and psychosocial information that will be collected on all patients as they enter the program and at designated time points thereafter. Young people will still be allowed to enter our program through any service, and the first provider they meet with will collect this information. The resultant data will then enable us to better understand the

needs of our patients, further refine our program, understand and disseminate outcomes and guide others who are developing similar programs.

On a final note, our program is run by—and the authors of this paper are—individuals who identify as cisgender. In our experience, it is not uncommon for cisgender practitioners to be coordinating or providing services to TGNC individuals. This is problematic and contributes to the power dynamic inherent in the relationship between a service provider and a client. As we move forward with this work, we seek to further integrate the voices of TGNC youth into our practice through the creation of a youth advisory board. In addition, we actively support and encourage TGNC adults and staff to pursue training and employment opportunities with us, so as to increase the number of TGNC-identified mental health and medical providers.

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